

**IN THE SUPREME COURT OF MISSOURI**

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**Supreme Court No. SC 85084**

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**TRACY L. FARMER – CUMMINGS**

**Employee/Appellant,**

**vs.**

**PERSONNEL POOL OF  
PLATTE COUNTY,**

**Employer/Respondent.**

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**SUBSTITUTE BRIEF OF RESPONDENT**

**PERSONNEL POOL OF PLATTE COUNTY**

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## **JURISDICTIONAL STATEMENT**

The Appellant has appealed the Decision of the Western District Court of Appeals affirming the Order of the Labor and Industrial Relations Commission of Missouri which determined the amount of past medical benefits to be reimbursed to Appellant. Jurisdiction of this Court is invoked under Article 5, Section 10 of the Missouri Constitution of 1945 amended 1976, and Rule 83.02 of the Missouri Rules of Civil Procedure.

## **STATEMENT OF FACTS**

Respondent refers this Court to the Court of Appeals decision, docketed as WD 60894 and the Court of Appeals original opinion, as modified, set forth in Farmer – Cummings vs. Future Foam, Inc., 44 S.W.3d 830 (Mo. App. 2001). In that opinion, the Court of Appeals remanded the case to the Labor and Industrial Relations Commission to determine the proper amount of past medical benefits to be awarded to the Appellant. The Respondent adopts the findings of fact as set forth in each of the Court of Appeals' decisions.

## Table of Cases

### CASES

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## **POINTS RELIED ON**

**I. THE APPELLATE COURT WAS CORRECT IN AFFIRMING THE LABOR AND INDUSTRIAL COMMISSION’S AWARD DETERMINING THE AMOUNT OF MEDICAL BENEFITS TO BE REIMBURSED TO APPELLANT BECAUSE THE COMMISSION ACTED**

**WITHIN ITS JURISDICTION IN THAT THERE WAS NO  
“CREDIT” APPLIED TO THE AMOUNT AWARDED.**

Smith vs. District II A and B, 59 S.W.3d 558 (Mo. App. 2001)

Uhlir v. Farmer, 91 S.W.3d 441, 444 (Mo. App. 2003)

Farmer vs. Personnel, 2002 WL 31654578 (Mo. App.)

Davies vs. Carter Carburetor, Div. ACF Industries, Inc.,  
429 S.W.2d 738 (Mo. 1968)

Weidower vs. ACF Industries, Inc., 657 S.W.2d 71(Mo.App.1983)

Mo. Rev. Stat. § 287.495 (Supp. 2002)

Mo. Rev. Stat. § 287.270 (Supp. 2002)

**II. THE APPELLATE COURT WAS CORRECT IN  
AFFIRMING THE LABOR AND INDUSTRIAL RELATIONS  
COMMISSION’S DETERMINATION OF THE AMOUNT OF  
PAST MEDICAL EXPENSE BECAUSE THERE IS  
SUBSTANTIAL AND COMPETENT EVIDENCE TO  
SUPPORT REDUCTIONS OF THE BILLS IN THAT THE  
AMOUNT AWARDED REPRESENTS THE AMOUNT THAT**

**THE APPELLANT WILL BE REQUIRED TO PAY FOR HER  
TREATMENT.**

Farmer vs. Personnel, 2002 WL 31654578 (Mo. App.)

Mann vs. Varney Construction, 23 S.W.2d 238 (Mo. App. 2000)

Lenzini vs. Columbia Foods, 829 S.W.2d 482 (Mo. App. 1992)

Mo. Rev. Stat. § 287.140.3 (Supp. 2002)

**I. The Appellate Court was correct in affirming the Labor and Industrial Commission’s award determining the amount of medical benefits because the Commission acted within its jurisdiction in that there was no “credit” applied to the amount awarded.**

## **ARGUMENT**

The Court of Appeals may not disturb the Commission's award unless the Commission acted without or beyond its power, the award was procured by fraud, the facts found do not support the award, or the award is not supported by sufficient competent evidence in the record. R.S. Mo. §287.495 (Supp. 2002). Review of an award of the Commission involves a two step process. Smith vs. District II A and B, 59 S.W.3d 558 (Mo. App. 2001). First, the reviewing court must examine the whole record, viewing the evidence and all reasonable inferences drawn therefrom in the light favorable to the award to determine if the award is supported by competent and substantial evidence. Smith at 562. Second, if the Appellate Court finds competent and substantial evidence to support the award, it then reviews the entire record, including evidence unfavorable to the award to determine whether the award is against the weight of the evidence. Id.

In workers' compensation cases, the Commission is the ultimate trier of fact. Uhlir vs. Farmer, 92 S.W.3d 441, 444 (Mo. App. 2003). Absent fraud, the factual determinations of the Commission are conclusive and binding on a reviewing court. Id. 445.

Appellant argues in all three of her points that the Appellate Court, in affirming the Commissions factual findings regarding the amount of medical bills, acted beyond its powers and statutory authority. This argument is unfounded. The

amount of benefits to be awarded is factual. The Commission's finding is conclusive. Had the Court of Appeals believed the Appellant was entitled to a different amount, it simply would have awarded that amount rather than remanding to the Commission for a determination of the amount due.

Further, the Appellant's reliance on R.S.Mo. §287.270 is misplaced. Neither the Court of Appeals or the Commission relied on §287.270 and in fact, specifically stated that this statute did not apply to this case. Farmer vs. Personnel Pool, 2002 WL 31654578,5 (Mo.App.2002). The cases which Appellant cites as authority on this issue are distinguishable from the case at bar in that Section 287.270, RSMo. (Supp. 2002), applied to them and does not apply here. In these cases, namely, Davies vs. Carter Carburetor, Div. ACF Industries, Inc., 429 S.W.2d 738 (Mo. 1968) and Weidower vs. ACF Industries, Inc., 657 S.W.2d 71 (Mo. App. 1983), the employer was trying to avoid liability for any amount of medical actually owed by the employee to the providers. The court, in both cases, refused to enhance the powers of the Commission by allowing it to take into account rights between the employee and the employee's personal insurance company.

In Davies, the employer attempted to stop the employee from making a claim since he had received payment under a Health and Accident policy. 429 S.W.2d at 752. The court did not accept this argument since it conflicted with Section 287.270 by taking into account other insurance of the employee. Id. The

Weidower case was substantially similar. The employee's personal insurance covered the costs initially. 657 S.W.2d at 75. The court stated that the employee's insurance company may seek reimbursement from the employee so the employer would not be allowed to pay the award directly to the hospital. Id. The employee would not be receiving a windfall since she was subject to having to reimburse her insurance provider for the bills that it paid and shouldn't have paid. Id.

In this case the Respondent was not given a "credit" for payments made by another source pursuant to the statute. Rather the Respondent's liability was simply limited to the amount of past medical benefits that the Appellant would actually be required to pay to the health care providers.

As no credit was found or awarded in this matter, R.S.Mo. §287.270 is in applicable. Attempting to inject the argument of a credit is an attempt to place at issue a theory which has no relation or application to this case.

**II. THE APPELLATE COURT WAS CORRECT IN  
AFFIRMING THE LABOR AND INDUSTRIAL RELATIONS  
COMMISSION'S DETERMINATION OF THE AMOUNT OF  
PAST MEDICAL EXPENSE BECAUSE THERE IS  
SUBSTANTIAL AND COMPETENT EVIDENCE TO**

**SUPPORT REDUCTIONS OF THE BILLS IN THAT THE AMOUNT AWARDED REPRESENTS THE AMOUNT THAT THE APPELLANT WILL BE REQUIRED TO PAY FOR HER TREATMENT.**

### **ARGUMENT**

Again the Appellant raises three points on appeal. The issues raised in all of her points are that the Court of Appeals erred in affirming the Commission's failure to include in its award past medical benefits charges that had been written off by the health care providers.

The Appellant fails to appreciate that the amount "incurred" or billed is not the actual amount paid, which is the fair and reasonable amount which the Missouri Workers' Compensation Act requires be paid. R.S.Mo. §287.140.3 (Supp. 2002). That section provides that the employer provide medical treatment as follows:

"All fees and charges under this Chapter shall be fair and reasonable, shall be subject to regulation by the Division or the Commission, or the Board of Rehabilitation in rehabilitation cases. A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this Chapter greater than the usual and customary fee the provider receives for the same treatment or service when the payor for

such treatment or service is a private individual or a private health insurance carrier.”

R.S.Mo § 287.140.3 (Supp. 2002)

Appellant is only entitled to recover that amount which is fair and reasonable which, as the Court of Appeals stated, must be interpreted to refer to an employee’s actual expense. Farmer-Cummings v. Personnel Pool, 2002 WL 31654578,7 (Mo.App.2002). The purpose of the reimbursement to Appellant is not to reward her, but to reimburse those amounts which must be paid; in other words, to reimburse for the medical expense actually paid, no more or no less. The evidence, in the form of the actual bills, is substantial, competent and overwhelming in that the amount awarded to Appellant is the amount that was either paid by Medicaid, other insurance and/or the balance due as set forth on the face of each bill. The Commission, in its Order which the Court of Appeals affirmed, painstakingly analyzed not only the summary of the medical bills incurred but the underlying bills themselves and determined that the Appellant would not ever be responsible for some of those charges which had been “written off” either by Medicaid, by other insurance, or simply written off by the provider. In a nutshell, the Commission reviewed each bill and determined the amount paid by Medicaid, other insurance or the Appellant, added the balance due and awarded the total. It

subtracted any amount which had been “written off” for which the Appellant would never be responsible or required to pay. While Appellant makes reference to a summary sheet of the bills offered into evidence, the Court of Appeals affirmed the Commission which found that the sheet did not correctly match the actual bills offered as the summary included write offs, clerical errors and charges for other patients. Thus, the decision to award the actual bills is based on the evidence before the trier of fact.

The only amounts reduced or deducted are those which have been “written off” and which will never be charged to the Appellant. Regardless of the basis of the reduction, the analysis is the same. The Appellant will only be required to pay the actual amount of the bill, not that which was originally billed.

Regarding the Medicaid payments, Mann vs. Varney Construction, 23 S.W.2d 238 (Mo. App. 2000) is conclusive. In Mann, the Appellant appealed a decision from the Commission ordering the Second Injury Fund to pay medical expenses but only to the extent that the health care providers accepted from Medicaid as full settlement payment of the amount submitted, and not the total of his original medical costs billed. Id. The medical costs, in Mann, for Appellant’s injury were \$130,085.13. Id. at 232. Of that amount, \$98,543.32 was submitted to Medicaid for payment and Medicaid paid \$19,547.50 to the healthcare providers as a full settlement payment of the amount submitted to Medicaid. Id. The

Commission affirmed the decision of the Administrative Law Judge and ordered the Second Injury Fund to pay the amount asserted as a Medicaid lien, plus an additional amount that was not covered by Medicaid. Id. The Court of Appeals cited R.S.Mo. §287.220.5 (Supp. 2002) as the basis for the Second Injury Fund to pay the reasonable and necessary expenses to cure and relieve the affects of the injury or disability. Id. The Appellant argued that under the statute, he should be reimbursed for the total amount of his medical bills instead of only the portion he would be liable for under Medicaid. Id. The Court of Appeals found that argument contrary to the intent of the statute. Id. The Court stated:

“Here, the Commission found the parties agree the total amount submitted to Medicaid will never be sought from Appellant. Appellant will only ever be responsible for the \$19,547.50 paid by Medicaid. Employees of uninsured Employers should not receive a windfall. We find no distinction between covered expenses paid by an employer and by the Second Injury Fund, and find an Employee should only be compensated for the Employee’s actual expenses as a result of the Employee’s injury when the employer is uninsured.”

Mann at 232.

In this case, as in Mann, the amount Appellant is requesting is not actually owed by her. The amount requested is higher than the amount due, as reflected on the face of the bills. The Commission determined that charges totaling \$55,519.33 were submitted to Medicaid but Medicaid had written off \$33,902.53; therefore, determining the only amount Appellant should be awarded is \$21,616.80. As in Mann, the extra amount is not a liability of the Appellant. Further, the analysis of those amounts paid by other insurance is the same. The Appellant is being awarded those amounts that have been paid by other insurance (\$4,077.29). Similarly, the amounts which have been written off will never be required to be paid by the Appellant. Lenzini vs. Columbia Foods, 829 S.W.2d 482 (Mo. App. 1992) supports the position that the amount to be awarded should not include those sums written off by the medical providers. Lenzini at 485. In Lenzini, the employer did not pay the medical expense through its Workers' Compensation carrier, but through its self insured medical plan. Lenzini at 485. The actual bills indicated that some of the amounts had been written off by the health care provider and therefore, the court allowed the employer a deduction for the medical bills written off by those health care providers. Lenzini at 487. The employee was only awarded those amounts his insurance company actually had to pay for his treatment. Id. In the instant case, this is precisely how the Commission made its determination of the amounts which had been paid by other insurance or the Appellant. The Appellant is

being awarded only the amounts the other insurance or she actually had to pay for her treatment.

Further, there is no way for Appellant to be liable for these write-offs. The Commission made a finding as to what the actual amount owed was and acted fully within its power, as the ultimate trier of fact, to do so. To allow Appellant to recover more than the amount for which the providers held her, Medicaid, and her private insurer responsible would result in an unjust windfall. Farmer, 2002 WL 31654578 at 6.

## **CONCLUSION**

The issues presented to the Court of Appeals were questions of fact. The decision of the Court of Appeals is supported by substantial evidence and is not against the weight of the evidence. That evidence is Appellant's own exhibits offered at the time of trial. The decision must, therefore, be affirmed.

Respectfully Submitted,

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## **CERTIFICATE OF COMPLIANCE AND SERVICE**

I, Stephanie Warmund, hereby certify as follows:

1. The attached brief complies with the limitations contained in Supreme Court Rule 84.06. as it contains 2747 words. The brief was completed using Microsoft Word 2000, in Times New Roman size 14 font.
2. Pursuant to Special Rule XXXII, the floppy disk filed with this brief contains a copy of this brief. It has been scanned for viruses using Norton Anti Virus program. According to that program, this disk is virus-free.
3. One true and correct copy of the attached brief and a floppy disk containing a copies of this brief were mailed, postage prepaid to: Mr. Kevin D. Meyers, 1125 Grand Avenue, Suite 900, Kansas City, MO 64106, and to Mr. Charles W. Gotschall, 4700 Belleview, Suite 215, Kansas City, MO 64112, Attorneys for Claimant/Appellant, on the \_\_\_\_ day of April, 2003.

\_\_\_\_\_  
Stephanie Warmund